THE CENTER OF HOPE RECOVERY MINISTRY
ENTRY ASSESSMENT

The individual applying to the waiting list has to fill out and sign this form in its entirety. If you give any false information or it is found that you purposely omitted any information then your application will be denied.

Thank you for your inquiry about The Center of Hope. The Center of Hope church has a Christ-centered, residential, 12-18 month recovery ministry. We are aiding individuals in redirecting their life by sharing God's values and principles. Our classes teach men and women with addictions to take responsibility for themselves and others while allowing God to reshape their lives. 2Corinthians 5:17..."Therefore if anyone is in Christ he is a New Creation; the old has gone, the new has come."

Please be informed that in order for your name to be added to our waiting list the entry assessment form must be completed and returned. At that time your application will be reviewed and you will receive a letter in the mail of acceptance or denial (if denied a reason and referrals to other facilities will be given). In order for us to keep you on our list you will have to contact us every week by phone or through the mail!!!! (if we do not hear from you, your name will be removed from the waiting list.) Please have your affairs in order realizing that we never know in advance when a bed might become available. When contacted, your bed will be held for 24 hours only. No exceptions.

NAME_____ TODAY'S DATE_____

PHONE _____
ADDRESS_____

_____
_____

DATE OF BIRTH_____MALE_____FEMALE_____
_

(Please list 2 methods of contact)
NAME_____
PHONE_____

ADDRESS_____
_____

NAME_____
PHONE_____

ADDRESS_____

_____

What is currently happening in your life?

_____

_____

_____

_____

_____

Have you ever been to our recovery ministry? (If yes, please explain circumstances of your leaving or being dismissed. Please include the year that you were here.)

_____

_____

_____

_____

Are you willing to spend 12-18 months in residential recovery?

_____

Are you incarcerated? _____ Where?

_____

LEGAL INFORMATION

ATTORNEY NAME_____

PHONE_____

ADDRESS_____

_____

P O NAME_____

PHONE_____

ADDRESS_____

_____

COURT REFERRAL OFFICER_____

PHONE_____

ADDRESS_____

_____

TASC OFFICER_____

PHONE_____

ADDRESS_____
_____

Have you ever been convicted of a sexual offense or do you currently have sexual charges pending?

_____

Are you required by a Judge to complete our recovery ministry?

_____

Judge_____ Phone_____ Address_____

LIST ANY AND ALL CASES THAT YOU HAVE EVER BEEN ARRESTED FOR BELOW:

CHARGE: _____ DATE_____ CO: _____COURT DATE_____
CHARGE: _____ DATE_____ CO: _____COURT DATE_____
CHARGE: _____ DATE_____ CO: _____COURT DATE_____
CHARGE: _____ DATE_____ CO: _____COURT DATE_____
CHARGE: _____ DATE_____ CO: _____COURT DATE_____
CHARGE: _____ DATE_____ CO: _____COURT DATE_____

We do not act as your lawyer. If you are in jail, you will need your lawyer to do the legal work for you. We are unable to provide transportation from jail. Your lawyer may contact Shawn Danford (men's list) or Heather Farmer (women's list) at (256) 236-9716 or 2906 Bynum Leatherwood Rd. Anniston, AL 36201 for further information.

DRUG HISTORY

What is your drug of choice? _____ Do you consider yourself addicted?
_____

Explain:
_____
__

The Center of Hope is not a detox facility. If you arrive at The Center and realize that you need detox we will not be able to hold your bed for you, however, at the time of detox completion with a release form from the physician, a place will be made available

for you at The Center.

MEDICAL CHECKLIST

Do you have problems with any of the following? Please circle all that apply.

1* HIGH/LOW BLOOD PRESSURE
2* KIDNEY/BLADDER
3* ASTHMA
4* DIABETES
5* TUBERCULOSIS
6* EPILEPSEY
7* VENERIAL DISEASE
8* MIGRAINE HEADACHES
9* SKIN SORES
10* TROUBLE BREATHING
11* MENTAL ILLNESS (please specify diagnosis)_____
12* OTHER (please explain)_____

List allergies_____ Are you disabled or handicap? _____

Do you have any long-standing health issues that cause you concern? _____

If so, please specify._____ __

(Women) are you pregnant? _____ if so, how many months? _____

Do you receive disability, SSI, or any other funds from the government? _____

Do you have insurance? (Medicare, Medicaid, BCBS, etc.)_____

LIST BELOW ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

MEDICATIONS/MG DOSE RX DATE QUANTITY PHYSICIAN REASON RX

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

LIST ANY MEDICATION(S) YOU SHOULD BE TAKING: (Prescribed)
_____

I, _____ attest that the above information is true and that all medications are prescribed for the labeled purposes and are currently the only medications I am using. YOU WILL NOT BE ALLOWED TO TAKE ANY MOOD-ALTERING, ANTI-DEPRESSANT, ANTI-ANXIETY, OR NARCOTIC PRESCRIPTIONS WHILE ENROLLED IN THE MINISTRY. WE DO NOT HAVE MEDICAL PERSONELL ON STAFF.

I, _____understand that The Center of Hope is a Christian Ministry. I am willing to commit to 12-18 month Discipleship Training School. I am willing and able to sleep on a mattress on the floor, bunk bed, or cot. I understand that I will have to work as a volunteer on the property.

The $215 intake fee is due upon acceptance, this fee is non-refundable. This fee is needed for teaching materials and curriculum.

Signature_____

Date_____

(By signing I agree to all above said statements and attest that all information given is true.)

OTHER LAUNDRY-(RESIDENT PURCHASES LAUNDRY DETERGENT)
PERSONAL HYGIENE PRODUCTS

CLOTHING

RESTRICTED CLOTHING GUIDELINES: NO SLEEVELESS CLOTHING, HALTER TOPS, TIGHT FITTING OR FIGURE FITTING CLOTHING, NO SLITS IN DRESSES/SKIRTS/SHORTS. ALL SHORTS, SKIRTS AND DRESSES MUST BE KNEE LENGTH OR NO MORE THAN 1" ABOVE THE KNEE.

WOMEN'S CLOTHING ALLOWANCE

OUTFITS defined as shirts, shorts (knee length), pants, skirts & dresses=12
PAJAMAS/NIGHT CLOTHES including undershirt or shorts=3
PURSES include book bags=2 SHOES including house slippers=5
BRAS=7 PANTIES=10 PANTY HOSE=unlimited
JACKETS including sweaters=3 SOCKS=10
THINGS NEEDED: toiletries, Twin sheets, Blanket, Pillow, Laundry detergent, Laundry Bag or Basket

MEN'S CLOTHING ALLOWANCE

PANTS=10 TENNIS SHOES=1 DRESS SHOES=2
SHIRTS=15 WORK SHOES=1 SOCKS=10
HATS=3 SPORT COAT=1 UNDERWEAR=10
TIES=4 SUITS=2 BELTS=3
THINGS NEEDED: Toiletries, Twin sheets, Blanket, Pillow, Laundry detergent

YOU WILL RECEIVE A LETTER IN THE MAIL OF ACCEPTANCE OR DENIAL OF THE APPLICATION. IF THIS FORM IS NOT FILLED OUT COMPLETELY YOUR NAME WILL NOT BE ADDED TO THE LIST. IT WILL BE MAILED BACK TO YOU FOR COMPLETION.